



## Durable Medical Equipment and Medical Supplies

### January 2006 • Bulletin 363

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#### DME Rate Adjustment

Effective for dates of service on or after February 1, 2006, the reimbursement rate for HCPCS code E1238 (wheelchair, pediatric size, folding, adjustable, without seating system) will be adjusted as follows due to the allowance paid by Medicare:

<u>Code</u>	<u>Purchase Rate</u>	<u>Monthly Rental Rate</u>
E1238	\$1,638.73	\$163.87

This adjustment is in accordance with *Welfare and Institutions Code*, Section 14105.48.

*The updated information is reflected on manual replacement page [dura cd 19](#) (Part 2).*

#### Medi-Cal Crossover Claim Reminder

Providers are reminded that when Medicare makes an adjustment on a previously paid Medicare claim, the resulting automatic crossover Medicare adjustment does not get processed by Medi-Cal. When a provider receives a Medicare adjustment, the Medicare claim for the adjusted amount must be submitted in hard copy form to Medi-Cal. Prior to submitting the new claim for the adjusted amount, the provider must void the original Medicare payment, or the adjusted claim will be denied with Remittance Advice Details (RAD) code **010: This service is a duplicate of a previously paid claim.**

To receive correct reimbursement from Medi-Cal for a previously reimbursed Medicare crossover claim, providers may file either a *Claims Inquiry Form* (CIF) or an appeal.

For information about completing a CIF, refer to the *CIF Special Billing Instructions* section in the appropriate Part 2 manual. For information about appeals, refer to the *Appeal Form Completion* section in the appropriate Part 2 manual.

*This information is reflected on manual replacement page [cif.sp 7](#) (Part 2).*

#### Procedure Code and Modifier(s) Combination on Claim and TAR Must Match

Effective for dates of service on or after March 1, 2006, the procedure code and modifier(s) combination on the claim submitted must match the procedure code and modifier(s) combination authorized on the *Treatment Authorization Request* (TAR). Failure to do so may result in denial of the claim.

**Note:** All current policies regarding the placement or order of modifiers on the claim and/or TAR remain the same.



### 837 v.4010A1 Electronic Claims with Attachments Now Available

Providers can now submit 837 v.4010A1 electronic claim submissions with attachments by either faxing the attachments or sending them electronically through an approved third-party vendor.

To utilize this new process, providers must be authorized to bill 837 v.4010A1 electronic claims. The fax process includes an *Attachment Control Form* (ACF), which is used as a coversheet for the supporting fax attachments. The ACF has a pre-printed Attachment Control Number (ACN) that submitters input on their electronic claim submission in the PWK segment. Providers submit the electronic claim, then fax the ACF and the attachments to Medi-Cal. Each ACF and corresponding attachments require a separate fax call. Each call to the fax server must include only one ACF as the first page followed by the attachment pages that correspond to that ACF. The phone number to fax attachments is 1-866-438-9377.

The electronic process involves approved third-party vendors that preprocess the attachments and send the images electronically on the provider's behalf. Medi-Cal links the faxed or electronic attachments to the appropriate electronic claim.

Providers have a maximum of 30 calendar days from the date of claim submission to submit the supporting faxed or electronic attachments. For further information regarding attachment submissions, please refer to the *Billing Instructions* section of the *837 Version 4010A1 Health Care Claim Companion Guide* on the Medi-Cal Web site ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)) by clicking the "HIPAA" link on the home page, then the "ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications" link and then the "Billing Instructions" link.

### Updated Crossover Billing Instructions for Outpatient Services

On October 24, 2005, new requirements for paper crossover claims for outpatient services were implemented to coincide with the automatic electronic crossover claims processed through United Government Services, LLC (UGS) or Mutual of Omaha. The major changes involve:

- Billing Medi-Cal with the same codes billed to Medicare
- Attaching a PC Print single claim detail version of the *Medicare National Standard Intermediary Remittance Advice* (Medicare RA) to all paper crossover claims for outpatient services
- Availability of electronic crossover billing
- New instructions for billing claims with more than 15 detail lines

Medi-Cal no longer allows the use of interim (local) codes for Medicare/Medi-Cal crossover billing. Providers should bill Medi-Cal using the same national codes displayed on the Medicare RA.

The PC Print single claim detail version of the Medicare RA is necessary for Medi-Cal claims processing, and claims received without the proper Medicare RA will be rejected. Some providers who did not previously elect to receive the electronic 835 remittance from Medicare are having difficulty complying with this requirement. In addition, if a provider's information is not updated to include the correct Medicare provider number on the Medi-Cal Provider Master File or the provider chooses to use a Medicare intermediary other than UGS or Mutual of Omaha, the claims can not cross over automatically and the provider must comply with the new paper billing instructions or bill Medi-Cal electronically.

To update the Medi-Cal Provider Master File with the appropriate Medicare provider number, submit a *Medi-Cal Supplemental Changes* form (DHS 6209). The form and instructions are available on the Medi-Cal Web site (from the home page, click "Provider Enrollment" and then "Application Forms"). The application must have an original signature and must include a letter on Medicare letterhead showing the provider's Medicare number. To expedite the process, the application may be sent to the California Department of Health Services (CDHS) Provider Enrollment Branch via overnight mail with a cover letter stating: "New Crossover Process. Please Expedite."

*Please see Crossover, page 3*

**Crossover** (*continued*)

Providers having difficulty obtaining the proper Medicare RAs are urged to bill these crossover claims to Medi-Cal electronically. Contact the Telephone Service Center (TSC) at 1-800-541-5555 or visit the “CMC Submission Instructions” page on the Medi-Cal Web site (from the home page, click “CMC” under “Provider Resources”) for information about electronic crossover billing.

Medi-Cal cannot process more than 15 lines per claim form for crossover claims for outpatient services. Therefore, crossover claims for outpatient services billed for more than 15 line items for Part B services billed to Part A Intermediaries require billing on two or more separate *UB-92 Claim Forms*. This process is called “split billing.”

Submit split-billed crossover claims according to the billing instructions in the *Medicare/Medi-Cal Crossover Claims: UB-92* section. In addition, these claims require special crossover billing procedures:

- Each split-billed claim form must include the applicable remarks in the *Remarks* area.
- The Medicare RA must be attached to each split bill claim.
- The claim detail lines entered on the claim form must be in the same order as the RA.
- Bracket and label the RA details lines that correspond with each split bill claim.

**Note:** The amount entered on each split-billed claim is determined by the provider, but the sum of the amounts on each split-billed claim must equal the summary data on the Medicare RA.

For additional information about the requirements for paper crossover billing for outpatient services, including billing examples and instructions for billing more than 15 claim lines, please refer to the *Medicare/Medi-Cal Crossover Claims: UB-92* and *Medicare/Medi-Cal Crossover Claims: UB-92 Billing Examples* sections in the appropriate Part 2 manual. More detailed billing examples will be published in future *Medi-Cal Updates* and posted to the Medi-Cal Web site.

*Updated information can be found on manual replacement pages medi cr ub 1 thru 4 and 7 thru 9 (Part 2) and medi cr ub ex 1, 2 and 5 thru 8 (Part 2).*

**Medical Supplies Additions and Deletions**

Effective for dates of service on or after February 1, 2006, Hollister, Inc. is a contracted manufacturer of the following medical supplies. All utilization controls and quantity limits for these medical supplies will be applied.

<u>Medi-Cal Billing Code</u>	<u>Manufacturer Code</u>	<u>Description</u>
9946M	HS	Gauze sponges, sterile, – specify manufacturer, catalog number and item supplied.
9980S	HS	Stomahesive paste 2 oz.
9980T	HS	Stomahesive powder 1 oz.
9993N	HS	Other intermittent catheters not specifically listed – specify manufacturer catalog number and item supplied.

Effective for dates of service after January 31, 2006, the following Hollister, Inc.-contracted ostomy product codes are no longer billable: 9976P, 9976R, 9915A, 9915J, 9915M, 9915W, 9919A, 9976Y, 9915H, 9915K, 9915P, 9915R, 9915S, 9915T, 9919D, 9919E, 9959D, 9959E, 9959F, 9959H, 9959J, 9959K, 9959L, 9977A, 9977B and 9977C.

*This information is reflected on manual replacement pages mc sup lst3 6 and 7 (Part 2).*

**Clarification: Transition Billing Period for Incontinence Medical Supplies**

Effective for dates of service on or after January 1, 2006, the list of adult briefs reimbursed by Medi-Cal is updated to reflect new contracts with manufacturers of incontinence supplies. As announced in the November 2005 *Medi-Cal Update* (Bulletin 619), starting on October 1, 2005, providers may purchase products from the new list but are not to bill Medi-Cal for these products for dates of service before January 1, 2006.

To allow providers more time to adjust their inventories, a transition billing period from January 1, 2006 through January 31, 2006 was established. During this transition period, providers may bill for both old and new incontinence supply adult briefs.

This transition period will delay the discontinuation of local level billing codes 9934V, 9985Q, 9986Q, 9986U, 9997S, 9997U, 9998A, 9998B, 9998C, 9998D, 9998E and 9998F, which were not used for the new list of adult briefs, to January 31, 2006. Therefore, effective for dates of service on or after February 1, 2006, these billing codes will no longer be reimbursable.

In addition, the transition period will allow the continuation of claim submissions coded with a “ZZ” modifier (unlisted manufacturer) using billing codes 9907K, 9907M, 9997Q, 9997T, 9997W and 9997Y for dates of service through January 31, 2006.

All other disposable adult brief products not included in a contract will no longer be Medi-Cal benefits after January 31, 2006.

Reimbursement for adult briefs on the current incontinence supplies list will continue at the current rate for dates of service on or before January 31, 2006, except for contracted products carried from the current list to the new list, and that have new reimbursement rates. New reimbursement rates for these products will be effective for dates of service on or after January 1, 2006.

Also effective January 1, 2006, providers are limited to dispensing no more than 200 youth and small briefs, per recipient, in a 27-day period; no more than 192 medium, regular and extra large briefs, per recipient, in a 27-day period; and no more than 216 large briefs, per recipient, in a 27-day period. Quantities exceeding this limitation require prior authorization. This quantity restriction is notwithstanding the existing \$165 limit per month, per recipient, for all incontinence supplies.

The current limit for incontinence creams is 540 grams in a 30-day period, per recipient, and for washes, 960cc's in a 30-day period, per recipient. Quantities exceeding these limits require prior authorization. Effective January 1, 2006, providers may dispense these supplies to recipients who have reached the quantity limit and bill Medi-Cal after waiting 27 days instead of 30 days.

**Note:** Providers risk claim denial if they dispense products appearing on the new list before January 1, 2006. The California Department of Health Services will allow additional sizes of disposable adult briefs that are not included in the contracts to be billed to Medi-Cal, with a *Treatment Authorization Request* (TAR), using a new miscellaneous incontinence billing code of 9999B.

Providers should retain the replaced manual pages from the *Incontinence Medical Supplies Product List* section as reference for submitting claims with dates of service on or before January 31, 2006.

January 2006

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Remove and replace:    cif sp 7/8  
                                  dura cd 19/20  
                                  hcfa sub 1/2 \*  
                                  incont lst 7 thru 18 \*  
                                  mc sup lst3 5 thru 8  
                                  medi cr ub 1 thru 4

Remove:                    medi cr ub 7  
Insert:                     medi cr ub 7 thru 9 (*new*)

Remove and replace:    medi cr ub ex 1/2

Remove:                    medi cr ub ex 5  
Insert:                     medi cr ub ex 5 thru 8 (*new*)

\* Pages updated due to ongoing provider manual revisions.